

**MEDI-CAL SUPPLEMENTAL APPLICATION****IMPORTANT**

- Read Instructions before completing the application
- Print clearly in blue ink.

*Return Completed Forms To:*  
 Department of Health Services  
 Provider Master File Unit  
 714 P Street, Room 950  
 P.O. Box 942732  
 Sacramento, CA 94234-7320  
 (916) 323-1945

**\*Please complete the entire application with current information. Supply the updated information which you check off in the "Action Requested" box in the appropriate section(s)**

**FOR STATE USE ONLY:**

<b>Medi-Cal Provider Number:</b> _____					<b>FOR STATE USE ONLY</b>	
<b>Action Requested:</b> _____ <b>Date:</b> _____					<b>Status Code:</b> _____	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Address and/or Phone Change  <input type="checkbox"/> Add Medicare Billing Number  <input type="checkbox"/> Change in Business Activities  <input type="checkbox"/> Reissue Provider Identification Number (PIN)  <input type="checkbox"/> Medical Transportation Changes           </div> <div style="width: 45%;"> <input type="checkbox"/> Add Tax Identification Number  <input type="checkbox"/> Add Doing-Business-As (DBA) Name  <input type="checkbox"/> Add Clinical Laboratory Improvement Amendment (CLIA)  <input type="checkbox"/> Deactivate Provider Number  <input type="checkbox"/> Other (Explain): _____           </div> </div>					<b>Effective Date:</b> _____	
<b>General Information:</b>					<b>PSRO:</b> _____	
1. Current Legal Provider Name, Business Name, Fictitious Business Name, and DBA:  _____  Is this a Fictitious Business Name? ____ Yes ____ No If yes, List the Fictitious Business Name Statement Number or Fictitious Business Name Permit Number: _____ Effective Date: _____ <small>(attach a copy of the recorded/stamped Fictitious Business Name Statement, or Fictitious Business Name Permit if applicable)</small>					<b>County Code:</b> _____	
2. Business Telephone Number:  <div style="display: flex; justify-content: space-between;"> <span>( _____ )</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span>(area code)</span> <span>(number)</span> </div>					<b>Provider Type:</b> _____	
3. Business Address:  <div style="display: flex; justify-content: space-between;"> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span>(street)</span> <span>(city)</span> <span>(county)</span> <span>(state)</span> <span>(9-digit Zip Code)</span> </div>					<b>Type Practice:</b> _____	
4. Pay To Address:  <div style="display: flex; justify-content: space-between;"> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span>(street)</span> <span>(city)</span> <span>(state)</span> <span>(9-digit Zip Code)</span> </div>					<b>Out-of-State IND:</b> _____	
5. Mailing Address:  <div style="display: flex; justify-content: space-between;"> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span>(street)</span> <span>(city)</span> <span>(state)</span> <span>(9-digit Zip Code)</span> </div>					<b>Group IND:</b> _____	
6. Tax Identification Number (attach copy of the Department of Treasury Internal Revenue Service Form):  _____ - _____			7. Social Security Number (If Sole Proprietor not using a Tax Identification Number – you must attach copy):  _____ - _____ - _____  Name of Sole Proprietor:  <div style="display: flex; justify-content: space-between;"> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span>last</span> <span>first</span> <span>middle</span> </div>		<b>Lab IND:</b> _____	
8. Medicare Billing Number:			9. Clinical Laboratory Improvement Amendment (CLIA) Certificate Number (attach copy):  State Laboratory License/Registration Number:		<b>Effective Date:</b> _____	
10. Seller's Permit Number (attach copy of permit):			11. License or Certificate Number:		<b>COS:</b> _____	
					<b>Begin Date:</b> _____	
					<b>End Date:</b> _____	
					<b>Specialty Code:</b> _____	
					<b>Date PMF Changed:</b> _____	
					<b>Operator ID:</b> _____	
					<b>Reviewed By:</b> _____	
					<b>Verified By:</b> _____	

Legal Name of Provider:

Date:

**FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY:**

12. The applicant or provider DOES ☐ or DOES NOT ☐ (check one) have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which the applicant or provider sells, rents, or leases durable medical equipment or medical supply items:

(Check One)

☐

A. In stock on the premises, or

☐

B. In a warehouse under the applicant or provider's direct control.

The business days and hours of operation are:

Days: \_\_\_\_\_

Hours: \_\_\_\_\_

If the applicant or provider does not have a retail business open to the public, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the applicant or provider engages in the sale of items in a warehouse under its direct control, provide the address of the warehouse:

STREET ADDRESS

CITY

STATE

ZIP CODE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who holds an ownership interest in the warehouse?

NAME

ADDRESS

TELEPHONE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(use additional sheets if necessary)

**FOR DURABLE MEDICAL EQUIPMENT AND PHARMACY PROVIDERS ONLY:**

13. Applicant or provider's business activities include the sale, rental, and/or lease of the types of items checked below. Give the percentage of each business activity in which the applicant or provider engages in. Total the percentages at the end of this item. Percentages must total 100%. (include licensure information of applicable business activities):

a. ☐ Beds \*\* \_\_\_\_\_%

1. ☐ Rental. Bureau of Home Furnishings and Thermal Insulation

Sanitizer License Number (attach copy): \_\_\_\_\_

Effective Date: \_\_\_\_\_

2. ☐ Sales. Bureau of Home Furnishings and Thermal Insulation

License Number (attach copy): \_\_\_\_\_

Effective Date: \_\_\_\_\_

\*\* If the business sells **AND** rents beds, it is only necessary to provide the license number and effective date of the Bureau of Home Furnishings and Thermal Insulation License as well as a copy of that license.

b. ☐ Orthotic Appliances(describe: \_\_\_\_\_) \_\_\_\_\_%  
(List and describe all Medi-Cal procedure codes on an attached sheet)

c. ☐ Incontinence Medical Supplies (describe): \_\_\_\_\_

You must comply with Article 3.7 of the Welfare and Institutions Code. If you are not selling incontinence supplies, enter zero (0) in the percentage column.

d. ☐ Ostomy Supplies (describe): \_\_\_\_\_ \_\_\_\_\_%

Medical Device Retailer Original Certificate Number (attach copy): \_\_\_\_\_

Effective Date: \_\_\_\_\_

Medical Device Retailer Original Exemptee Certificate Number (attach copy): \_\_\_\_\_

Name of Exemptee: \_\_\_\_\_ Effective Date: \_\_\_\_\_

e. ☐ Infusion equipment and supplies (describe): \_\_\_\_\_ \_\_\_\_\_%

Legal Name of Provider:

Date:

13. **Continued**

- f. ☐ Oxygen Equipment and supplies: \_\_\_\_\_ %  
Medical Device Retailer Original Certificate Number (attach copy): \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Medical Device Retailer Original Exemptee Certificate Number (attach copy): \_\_\_\_\_  
Name of Exemptee: \_\_\_\_\_ Effective Date: \_\_\_\_\_
- g. ☐ Urinary catheters, bags, etc. (describe): \_\_\_\_\_ %  
Medical Device Retailer Original Certificate Number (attach copy): \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Medical Device Retailer Original Exemptee Certificate Number (attach copy): \_\_\_\_\_  
Name of Exemptee: \_\_\_\_\_ Effective Date: \_\_\_\_\_
- h. ☐ Wheelchairs: \_\_\_\_\_ %  
Bureau of Home Furnishing and Thermal Insulation Furniture and Bedding  
Retailer License Number (attach copy): \_\_\_\_\_  
Effective Date: \_\_\_\_\_
- i. ☐ Prescribed Drugs (**PHARMACY ONLY – DME DISREGARD**) \_\_\_\_\_ %  
California State Board Of Pharmacy Permit Number: \_\_\_\_\_  
Expiration date (attach copy of permit and renewal, if applicable): \_\_\_\_\_  
Drug Enforcement Agency Registration Certification Number: \_\_\_\_\_  
Expiration date (attach copy of the certificate): \_\_\_\_\_  
National Association of Boards of Pharmacy Number: \_\_\_\_\_
- TOTAL** (Must equal 100%): \_\_\_\_\_ %

**FOR PHARMACIES ONLY:**

14. Name of the Pharmacist-In-Charge:

\_\_\_\_\_  
(last) (first) (middle)

15. Pharmacist-In-Charge Driver's License or State Issued Identification Card Number and state of issuance (Attach copy):

16. Pharmacist-In-Charge Social Security Number (Attach copy):

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
(Provision of the social security number is optional)

17. Pharmacist-In-Charge License Number: (Attach a copy of license and renewal, if applicable):

18. The applicant or provider (check one) DOES ☐ or DOES NOT ☐ have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations in which the applicant or provider engages in sales of items:

- (Check One) ☐ A. In stock on the premises, or  
☐ B. In a warehouse under the applicant's or provider's direct control.

The business days and hours of operation are:

Days: \_\_\_\_\_

Hours: \_\_\_\_\_

If the applicant or provider does not have a retail business open to the public, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Legal Name of Provider:		Date:	
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**18. (Continued)**

If the applicant or provider engages in the sale of items in a warehouse under its direct control, provide the address of the warehouse:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who holds an ownership interest in the warehouse?		TELEPHONE
NAME	ADDRESS	
_____	_____	_____
_____	_____	_____

(use additional sheets if necessary)

**FOR MEDICAL TRANSPORTATION PROVIDERS ONLY:**

**19. Vehicle or Air Ambulance Information** (Attach copy(ies) of certificates(s): **SEE INSTRUCTIONS**)

Ambulance:

CHP Certificate Number	Issue Date	Vehicle Identification Number(s)	Make and Model of Vehicle	Year	License
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

(Attach separate sheet if necessary)

Litter and/or wheelchair Vans:

Vehicle Identification Number(s)	Make and Model of Vehicle	Year	License Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Attach separate sheet if necessary)

Air Ambulance:

FAA Certificate Number	Name and Address where aircraft is hangared
_____	_____
_____	_____

(Attach separate sheet if necessary)

**20. Hours of Operation**

The business days and hours of operation are:

Days: \_\_\_\_\_

Hours: \_\_\_\_\_

**21. Geographic Area(s) Served** (List City/County-attach copy of permit)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**22. Driver or Pilot Information** (Attach copy(ies) of driver's license(s) and DMV DL-51(s): **SEE INSTRUCTIONS**)

Driver's or Pilot's Name(s)	Driver's or Pilot's License Number	Year of Expiration	DMV DL-51 Effective Date	DMV DL-51 Expiration
_____	_____	_____	____/____/____ - ____/____/____	____/____/____
_____	_____	_____	____/____/____ - ____/____/____	____/____/____
_____	_____	_____	____/____/____ - ____/____/____	____/____/____

(Attach separate sheet if necessary)

Ensure the following documents are attached to the application (as applicable):

- ☐ CHP Certificate(s)
- ☐ Certificates of Adjustment for Brake and Lamp Adjustment
- ☐ DMV commercial vehicle registration
- ☐ Proof of full coverage commercial insurance for each vehicle  
(Vehicle Identification Number MUST be listed on policy)
- ☐ FAA Certificate
- ☐ Copy of DMV driving history printout for each driver

- ☐ Copy of FAA Pilot's License for each pilot
- ☐ Copy of California Driver's License for each driver
- ☐ Copy of American Red Cross certificates (or equivalent) for first aid and CPR for each driver
- ☐ DMV DL-51 form signed by a physician for each driver
- ☐ Copy of standard pre-employment drug and alcohol tests lab results for each driver

Legal Name of Provider: _____		Date: _____	
<b>Information on Individual Signing this Application:</b>			
23. Printed Name of Individual Signing this Application: _____			
_____ (last)		_____ (first) _____ (middle)	
24. Driver's License or State Issued Identification Card Number and state of issuance (provide copy): _____		25. Social Security Number (provide copy): _____ _____-_____-_____ (Provision of the Social Security Number is optional)	
26. Date of Birth: _____		27. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<p><b>28. I declare under penalty of perjury under the laws of the state of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief.</b></p> <p><b>I declare that I have the authority to legally bind the applicant or provider.</b></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>Signature of the person authorized to bind the applicant or provider:</b></p> <p>_____</p> <p>(blue ink only)</p> <p>Executed at _____</p> <p>_____, _____, on _____.</p> <p style="text-align: center;">(city) (state) (date)</p> </div> <div style="width: 45%;"> <p><b>Title:</b></p> <p>_____</p> </div> </div>			
29. Notary*: _____			
<p><small>*Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, do <u>not</u> have to have the application notarized.</small></p>			

**Privacy Statement  
(Civil Code Section 1798 et seq.)**

All information requested by the application, the disclosure statement and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and the deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare fiscal intermediaries, Health Care Financing Administration, Office of the Inspector General, and Medicaid and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, 714 P Street, Room 950, Sacramento, CA 95814, (916) 323-1945.

### INSTRUCTIONS FOR COMPLETION OF SUPPLEMENTAL PROVIDER APPLICATION

This form is a supplemental application for changes to the provider master file. Providers may be subject to an onsite inspection prior to the Department making the requested changes on the provider file. Providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application, the attached disclosure statement and a provider agreement must also be completed for enrollment or continued enrollment.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enter your Medi-Cal provider number in the space provided.

**Action Requested:**

Enter the date you are completing the application.

Check the applicable action you would like made to the provider master file. If checking "Other", please explain. You are required to complete the entire form with current information. For the sections where you are providing information which you have checked a box under "Action Requested", provide the updated information.

**General Information:**

1. Current Legal Provider Name, Business Name, Fictitious Business Name, and DBA means the legal business name listed with the Internal Revenue Service (IRS). If this is a Fictitious Business Name, provide the Fictitious Business Name Statement or Fictitious Name Permit Number and effective date. Attach a clearly legible recorded-stamped copy of the Fictitious Business Name Statement or Fictitious Name Permit with the application.
2. Business Telephone means the primary business telephone number used at the business location. A beeper number, answering service, pager, facsimile machine, cellular phone, biller or billing service, or answering machine shall not be used as the primary business telephone.
3. Business Address means the actual business location including the street name and number, room or suite number or letter, city, county, state, and 9-digit zip code. A post office box or commercial box is not acceptable.
4. Pay To Address means the address to which payment will be mailed. The Pay To address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and 9-digit zip code.
5. Mailing address is where the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
6. List the Tax Identification Number issued by the Internal Revenue Service (IRS) under the name of the applicant or provider. Attach a clearly legible copy of the IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (confirmation notification), or Form 2363.
7. If the business is a sole proprietorship not using a Tax Identification Number, provide the social security number of the sole proprietor. Provide the sole proprietor's name. Provide a clearly legible copy of the social security card.
8. Insert the Provider's Medicare Billing Number.
9. Insert the Clinical Laboratory Improvement Amendment (CLIA) Number. Attach a copy of the CLIA certificate. Provide the State Laboratory License/Registration Number. If not applicable, write "N/A".
10. Insert the Seller's Permit Number, as issued by the California Board of Equalization. Attach a copy of the seller's permit. If not applicable, write "N/A".
11. Insert the provider's license or certificate number. Attach a legible copy with the application.

■ Write the Provider Name and Date on the top of page 2.

**For Durable Medical Equipment Providers Only:**

12. Provide the following information:
  - ☐ Whether the provider does or does not have a retail business open to the public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which the applicant or provider sells, rents, or leases durable medical equipment or medical supply items:
  - ☐ Whether the provider engages in the sale of items either in stock on the premises or in a warehouse under the provider's direct control.
  - ☐ The days and hours of operation.
  - ☐ If this is not a retail business open to the public, explain why.
  - ☐ If the sales of items are of items housed in a warehouse under the provider's direct control, provide the address of the warehouse.
  - ☐ The name(s), address(es), and telephone number(s) of who holds an ownership interest in the warehouse. Use additional sheets if necessary.

**For Durable Medical Equipment and Pharmacy Providers Only:**

13. Check the applicable business activities of the provider and give the percentage of those activities. Attach copies of all applicable licenses and/or certifications. Item 'i' applies to Pharmacy Providers only and Durable Medical Equipment Providers should disregard this question by writing "N/A" in the percentage column.

■ Write the Provider Name and Date on the top of page 3.

**For Pharmacy Providers Only:**

14. Provide the first, middle, and last name of the pharmacist-in-charge at the business location.
15. Provide the Driver's License or State Issued Identification Card Number and state of issuance of the pharmacist-in-charge. Attach a clearly legible copy of the Driver's License or State Issued Identification card with this application.
16. Provide the Social Security Number of the pharmacist-in-charge. Attach a clearly legible copy of the social security card with this application. Provision of the Social Security Number is optional.
17. Provide the license number of the pharmacist-in-charge.
18. Provide the following information:

- ☐ Whether the provider does or does not have a retail business open to the public that meets all local laws and ordinances regarding business licensing and operations.
- ☐ Whether the provider engages in the sale of items either in stock on the premises or in a warehouse under the provider's direct control.
- ☐ The days and hours of operation.
- ☐ If this is not a retail business open to the public, explain why.
- ☐ If the sales of items are of items housed in a warehouse under the provider's direct control, provide the address of the warehouse.
- ☐ The name(s), address(es), and telephone number(s) of who holds an ownership interest in the warehouse. Use additional sheets if necessary.

■ Write the Provider Name and Date on the top of page 4.

#### **For Medical Transportation Providers Only:**

19. Provide the following Vehicle or Air Ambulance Information:

Ambulance:

- ☐ Certificate number issued by the California Highway Patrol. Attach a clearly legible copy of the certificate with the application.
- ☐ Issue date.
- ☐ Vehicle Identification Number of each vehicle that will be used to transport beneficiaries.
- ☐ Make and Model of vehicle.
- ☐ Year of vehicle.
- ☐ License plate number of vehicle.

Litter and/or wheelchair Vans:

- ☐ Vehicle Identification Number of each vehicle that will be used to transport beneficiaries.
- ☐ Make and Model of vehicle.
- ☐ Year of vehicle.
- ☐ License plate number of vehicle.

Air Ambulance:

- ☐ Certificate number issued by the Federal Aviation Administration. Attach a clearly legible copy of the certificate with the application.
- ☐ Name and address where the aircraft is hangared. This statement must also be on your company letterhead and be attached with the application.

- ☐ Attach a copy of the Certificates of Adjustment for Brake and Lamp Adjustment with the application.
- ☐ Attach a copy of the DMV commercial vehicle registration with the application.
- ☐ Attach a copy of the proof of full coverage commercial insurance for each vehicle. The Vehicle Identification Number MUST be listed on the policy)

20. Hours of Operation - means the business days and hours the provider is available for service to Medi-Cal beneficiaries.

21. Geographic Area(s) Served - means those areas which the provider will be transporting Medi-Cal beneficiaries. Attach a copy of the city/county business license/permit with the application. If the city/county does not require a license/permit, you must attach a letter from that city/county with the application which states the city/county does not require a license/permit. It is the applicants or providers responsibility to verify with the city/county in which transportation services will be provided for vehicle and driver's permits. If you intend to conduct business in either the City of Los Angeles or the City of San Diego, you must apply for their vehicle and driver's permits. For more information contact either the City of Los Angeles Department of Transportation or the San Diego Metropolitan Transit Development Board.

#### **Driver or Pilot Information**

22. Provide the following Driver or Pilot Information:

- ☐ Full Legal Name of Driver or Pilot.
- ☐ Driver's or Pilot's License Number - means the number issued by the California Department of Motor Vehicles on the California Driver's License or the number issued by the Federal Aviation Administration on the pilot's license of the individual listed. Attach a clearly legible copy of the license for each driver or pilot with the application.
- ☐ Indicate the expiration date.
- ☐ Indicate the effective and expiration dates of the driver's Department of Motor Vehicles form DL-51 medical examination report. Attach a clearly legible copy of the DL-51 with the application.

#### **Information on Individual Signing the Application:**

- 23. Printed Name of individual signing the application means the first, middle, and last name of any individual acting on behalf of the provider and with the authority to legally bind the provider when applying to the Department for changes to the provider master file.
- 24. Provide the Driver's License or State Issued Identification Card Number and state of issuance of the individual named in number 23. Attach a clearly legible copy with the application.
- 25. Provide the Social Security Number of the individual named in number 23. Attach a clearly legible copy of the social security card with the application. Provision of the Social Security Number is optional.
- 26. List the date of birth of the individual named in number 23.
- 27. List the gender of the individual named in number 23.

■ Write the Provider Name and Date on the top of page 5.

28. An original signature in blue ink of the individual listed in number 23 is required. Also provide the title of the person signing the application. Include the city, state, and date where and when the application was signed. Include the city, state, and date in the statement regarding where and when the application was executed.
29. The application is to be notarized by a Notary Public. Applications received without the notarization will be returned to the applicant or provider as incomplete. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, do not have to have the application notarized.
- 



**Did you remember to enclose (as applicable):**

- ☐ Copy of Fictitious Business Name Statement or Fictitious Name Permit
- ☐ Copy of Tax Identification Verification
- ☐ Copy of Seller's Permit
- ☐ CLIA Certificate
- ☐ Copy of License or Certificate
- ☐ Copy of Licenses associated with business activities (as applicable):
  - ☐ Sanitizer License
  - ☐ Bureau of Home Furnishings and Thermal Insulation License
  - ☐ Medical Device Retailer Certificate
  - ☐ Medical Device Retailer Exemptee Certificate
  - ☐ Bureau of Home Furnishing and Thermal Insulation Furniture and Bedding Retailer License
- ☐ List of Medi-Cal Procedure Codes for Orthotic Appliances
- ☐ Copy of Pharmacist-In-Charge Driver's License or Identification Card and Social Security Card
- ☐ Copy of Pharmacist-In-Charge License
- ☐ CHP Certificate(s)
- ☐ FAA Certificate
- ☐ Copy of driver's license for each driver
- ☐ Copy of American Red Cross certificates for first aid and CPR for each driver
- ☐ DMV DL-51 form signed by a physician for each driver
- ☐ Copy of standard pre-employment drug and alcohol tests lab results for each driver
- ☐ Copy of DMV driving history printout for each driver
- ☐ Copy(ies) of city/county business license/certificate
- ☐ Certificates of Adjustment for Brake and Lamp Adjustment
- ☐ DMV Commercial Vehicle Registration
- ☐ Proof of full coverage commercial insurance for each vehicle (Vehicle Identification Number MUST be present on the policy)
- ☐ Copy of driver's license or identification card of person completing application
- ☐ Copy of social security card of person completing application
- ☐ Notarization of application, disclosure and provider agreement